

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

TO: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER:

01 - 01 - 01 - 04

2. STATE:

Idaho

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

MAR 30 2001

01/01/01

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

BIPA of 2000, Section 702

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B, page 1.b.
Attachment 4.19-B, pages 5 & 5.1

7. FEDERAL BUDGET IMPACT:

a. FFY 2001 \$ 100,000
b. FFY 2002 \$ 130,000

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):

Attachment 4.19-B, page 1.b.
Attachment 4.19-B, page 5 & 5.1

10. SUBJECT OF AMENDMENT:

Change in reimbursement method for Federally Qualified Health Centers and Rural Health Clinics as required by the Benefit Improvement and Protection Act of 2000, Section 702.

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Karl B. Kurtz

13. TYPED NAME:

KARL B. KURTZ

14. TITLE:

Director

15. DATE SUBMITTED:

3/29/2001

16. RETURN TO:

JOSEPH R. BRUNSON
IDAHO DEPARTMENT OF HEALTH & WELFARE
DIVISION OF MEDICAID
PO BOX 83720
BOISE ID 83720-0036

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

MAR 30 2001

18. DATE APPROVED:

JUN 21 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

JAN 1 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

Judith Rosenberg, Acting ARRA

21. TYPED NAME:

Teresa L. TRIMBLE

22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID AND STATE OPERATIONS

23. REMARKS:

ASSOCIATE REGIONAL ADMINISTRATOR
DIVISION OF MEDICAID AND STATE OPERATIONS

3/29/01

Boise

- v. Patient Education: Outpatient Hospital Diabetic Education and Training Programs - Limited diabetic education and training services rendered through programs recognized by the American Diabetes Association, or provided by Certified Diabetes Educators are reimbursed at the lower of the provider's actual customary charge, or the allowable charge as established by the Department's fee schedule.
- b. **Rural Health Clinics** - Specifically included services are services of physicians, clinical psychologists, clinical social workers, physician assistants, nurse practitioners, nurse midwives, or other specialized nurse practitioners, supplies that furnished incidental to professional services, part-time visiting nurses' care and related medical supplies furnished to home-bound recipients in a home health shortage area, and other ambulatory services furnished by the clinic.
 - i. Payment for Rural Health Clinics services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.
 - ii. All Rural Health Clinics services are reimbursed on a prospective payment system beginning with fiscal year 2001 with respect to services furnished on or after January 1, 2001 and each succeeding fiscal year.
 - iii. This payment is set prospectively using the total of the clinic's reasonable costs determined by the audited cost report for clinic fiscal years 1999 and 2000, adjusted for any increase or decrease in the scope of services furnished during clinic fiscal year 2001. The combined costs for these periods are divided by the total number of visits for the two-year period to arrive at a cost per visit. These encounter rates will be inflated from the mid-point of the cost reporting period to the mid-point of the perspective rate period using the Medicare Economic Index (MEI). This inflated per visit rate is the prospective rate for the period 1-1-2001 to 9-30-2001. Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each clinic is paid the amount (on a per visit basis) equal to the amount paid in the previous Federal fiscal year, increased by the percentage increase in the MEI for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the clinic during that fiscal year. The Rural Health Clinic is responsible for supplying the needed documentation to the State regarding increase or decrease in the Rural Health Clinic's scope of services. The per visit payment rate shall include costs of all Medicaid coverable services and costs of other ambulatory services provided in the clinic.
 - iv. Until the State transitions to the prospective payment system, the State will reimburse RHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system is in place, the State will retroactively reimburse RHCs to the effective date, January 1, 2001, according to the BIPA 2000 requirements.
 - v. For newly qualified RHCs after Federal fiscal year 2000, initial payments are established either by reference to payments to other clinics in the same or adjacent areas with similar caseload, or in the absence of other clinics, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other clinics and adjustment for any increase/decrease in the scope of services furnished by the clinic during that fiscal year.
 - vi. In the case of any RHC that contracts with a managed care organization, supplemental payments will be made quarterly to the clinic for the difference between the payment amounts paid by the managed care organization and the amount to which the clinic is entitled under the prospective payment system.

TN# 01-004

Supersedes TN# 97-002

Approval Date: 6-21-01

Effective Date: 1-1-01

2.c.iv. FQHC (Continued)

- b. Offset, Reclassified or Excluded Costs - The costs of the specific following items and services are to be offset, reclassified, or excluded from Medicaid reasonable costs:
- (1) Excessive and unreasonable costs which violate the prudent buyer concept are excluded from total costs; and
 - (2) Medicaid payments for presumptive eligibility screenings shall be offset against the appropriate cost centers at cost settlement; and
 - (3) Special services related to pregnancy with the exception of nutritional education and dietary monitoring and counseling will be included as encounters in cost report statistics and for cost settlement;
 - (a) Other ambulatory services not included in the definition of an encounter shall be reimbursed at one hundred percent (100%) of reasonable costs;
 - (b) EPSDT screening and the incidental services are a patient encounter. Services and items specifically not included in the Idaho title XIX state plan but authorized as EPSDT services through section 6403 of O.B.R.A. 1989 may be reimbursed on either a fee for service basis or reported as other ambulatory services for cost settlement;
 - (c) EPSDT services not outside the scope of Medicaid will be reimbursed at 100% of reasonable costs for MA recipients up to and including the month of their twenty-first birthday. Limits upon the number or scope of services for EPSDT recipients are not waived for an FQHC provider.
- c. Payment for Federally Qualified Health Center services conforms to section 702 of the Benefits Improvement and Protection Act (BIPA) of 2000.
- 1) All Federally Qualified Health Center services are reimbursed on a prospective payment system for services furnished on or after January 1, 2001 and each succeeding fiscal year.
 - (2) This payment is set prospectively using the total of the center's reasonable costs determined by the audited cost report for fiscal years 1999 and 2000, adjusted for any increase or decrease in the scope of services furnished during center fiscal year 2001. The combined costs for these periods are divided by the total number of visits for the two-year period to arrive at a cost per visit. These encounter rates will be inflated from the mid-point of the cost reporting period to the mid-point of the perspective rate period using the Medicare Economic Index (MEI). This inflated per visit rate is the prospective rate for the for the period 1-1-2001 to 9-30-2001. Beginning in Federal fiscal year 2002, and for each fiscal year thereafter, each center is paid the amount (on a per visit basis) equal to the amount paid in the previous Federal fiscal year, increased by the percentage increase in the MEI for primary care services, and adjusted for any increase or decrease in the scope of services furnished by the center during that fiscal year. The FQHC is responsible for supplying the needed documentation to the State regarding increase or decrease in the FQHC's scope of services. The per visit payment rate shall include costs of all Medicaid coverable services and costs of other ambulatory services provided in the center.

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- (3) Until the State transitions to the prospective payment system, the State will reimburse FQHCs based on the provisions contained in the State Plan as of December 31, 2000. Once the prospective payment system is in place, the State will retroactively reimburse FQHCs to the effective date, January 1, 2001, according to the BIPA 2000 requirements.
- (4) For newly qualified FQHCs after Federal fiscal year 2000, initial payments are established either by reference to payments to other centers in the same or adjacent areas with similar caseload, or in the absence of other centers, by cost reporting methods. After the initial year, payment is set using the MEI methods used for other centers and adjustment for any increase/decrease in the scope of services furnished by the center during that fiscal year.
- (5) In the case of any FQHC that contracts with a managed care organization, supplemental payments will be made quarterly to the center for the difference between the payment amounts paid by the managed care organization and the amount to which the center is entitled under the prospective payment system.

v. **Reasonable Costs of FQHC Services.**

- a. Overhead costs will be allocated to core services, each category of other ambulatory services, and nonallowable services in proportion of the cost of each to total costs.
- b. Payments under the National Health Service Corps reimbursement program for employee salaries or wages will not be offset against allowable costs.

vi. **Cost Report filing Requirements.** Each FQHC provider will submit the completed Medicaid Cost Report form containing such information and worksheets as the Department's Medical Assistance Unit requires to determine Medicaid reasonable costs. The deadline will be the last day of the third month following the provider's fiscal period unless a delay is granted by the Department's Medical Assistance Unit.

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